

SERFF Tracking Number:	APLE-126862615	State:	Arkansas
Filing Company:	IA American Life Insurance Company	State Tracking Number:	47063
Company Tracking Number:	UL201		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	SL+App2		
Project Name/Number:	SL+App2/UL201		

Filing at a Glance

Company: IA American Life Insurance Company

Product Name: SL+App2

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: APLE-126862615 State: Arkansas

SERFF Status: Closed-Approved-
Closed

Co Tr Num: UL201

Author: Linda Dymacek

Date Submitted: 10/15/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 10/19/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: SL+App2

Project Number: UL201

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/19/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/19/2010

Created By: Linda Dymacek

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Linda Dymacek

Filing Description:

This filing is an application which will be used for a universal life policy that was previously approved by your department under APLE-126214924. It does not replace any existing policy forms currently in use. The forms contain no unusual or controversial features or language that deviates from normal insurance industry standards. The form will be used by individuals in the general public through licensed agents.

Company and Contact

Filing Contact Information

Linda Dymacek, Compliance Analyst

linda.dymacek@iaplife.com

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17550 N Perimeter Drive 888-473-5540 [Phone] 8350 [Ext]
 Suite 210 480-502-5088 [FAX]
 Scottsdale, AZ 85255

Filing Company Information

IA American Life Insurance Company CoCode: 91693 State of Domicile: Georgia
 17550 N. Perimeter Dr. Group Code: 315 Company Type: LAH
 Suite 210 Group Name: Industrial Alliance State ID Number:
 Group
 Scottsdale, AZ 85255-0131 FEIN Number: 13-3036472
 (480) 473-5540 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 a[[lication filed speparately = \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
IA American Life Insurance Company	\$50.00	10/15/2010	40800690

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/19/2010	10/19/2010

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Disposition

Disposition Date: 10/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	SecureLife Plus Life Insurance Application		Yes

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Form Schedule

Lead Form Number: UL201

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	UL201	Application/ SecureLife Plus Life Enrollment Insurance Application Form	Initial		45.300	UL201.pdf

Proposed Insured: _____ <div>(First) (Middle) (Last)</div>						_____ Phone				_____ Best time to call		<input type="checkbox"/> am <input type="checkbox"/> pm					
Address: (No. & Street) _____						E-mail Address _____@_____											
City: _____		State: _____		Zip Code: _____													
<div>Sex</div> <div><input type="checkbox"/> Male</div> <div><input type="checkbox"/> Female</div>		<div>Date of Birth</div> <div>Mo. Day Yr</div> <div>/ /</div>		Age _____		State of Birth _____		SS# _____ — _____		Height: _____ ft _____ in		Occupation: _____					
				DL# _____				Weight: _____ lbs		Annual Salary: \$ _____							
Owner: Name _____ SS# _____ Address: _____																	
Payor: Name _____ SS# _____ Address: _____																	
Primary Primary Beneficiary _____ SS# _____ Relationship _____																	
Insured: Contingent Beneficiary _____ SS# _____ Relationship _____																	
Plan: _____ Face Amount \$ _____						<input type="checkbox"/> Non-Tobacco		<input type="checkbox"/> Tobacco		<input type="checkbox"/> Preferred							
Have you used tobacco or nicotine products in the past 12 months?						<input type="checkbox"/> Yes		<input type="checkbox"/> No	or during the past 36 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Universal Life (select option):						<input type="checkbox"/> Option 1 (Face Amount Only)		<input type="checkbox"/> Option 2 (Face Amount Plus Cash Value)									
Riders: <input type="checkbox"/> Waiver of Specified Premium \$ _____						<input type="checkbox"/> Term 10 or		<input type="checkbox"/> Term 20		\$ _____							
<input type="checkbox"/> Waiver of Monthly Deduction						<input type="checkbox"/> Additional Insured Rider:		<input type="checkbox"/> Term 10		<input type="checkbox"/> Term 20		\$ _____					
<input type="checkbox"/> ADB \$ _____						<input type="checkbox"/> Child Rider (Units):											
Mode: <input type="checkbox"/> Bank Draft		<input type="checkbox"/> Draft 1st Prem on Req. Date		CWA: <input type="checkbox"/> E-Check Immediate 1st Prem		Mail Policy To: <input type="checkbox"/> Agent		<input type="checkbox"/> Insured		<input type="checkbox"/> Owner							
<input type="checkbox"/> Other		Modal Prem \$ _____		<input type="checkbox"/> Collected \$ _____		Policy Date Request: _____ / _____ / _____											
Do you have any existing life or disability insurance or annuity contract?						<input type="checkbox"/> Yes <input type="checkbox"/> No		Company _____									
Will you replace an existing life or disability insurance policy or an annuity?						<input type="checkbox"/> Yes <input type="checkbox"/> No		Policy # _____		Coverage Amount \$ _____							
Other Proposed Insureds: Name		Rider		Amt.		Sex		Birthdate		St. of Birth		Height		Weight		Relationship	

SECTION A: Answer Questions 1 through 3 for all Proposed Insureds. (circle all conditions that apply)

1. **Within the past 10 years**, has any Proposed Insured taken medication or been treated for, or been diagnosed by a medical professional with:

a. high blood pressure, heart attack, angina, arrhythmia, stroke, aneursym, or any heart or circulatory disease or disorder?

b. diabetes, cirrhosis, hepatitis, pancreatitis, Crohn’s disease, ulcerative colitis, or any digestive or liver disease or disorder?

c. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea or any respiratory disease or disorder?

d. cancer in any form, migrane headaches, anemia, seizure, bi-polar disorder, schizophrenia, or mental or nervous disorder?

e. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease?

f. connective tissue disease, systemic lupus (SLE), arthritis, or any disorder of the back, joints, muscles, or nervous system?

g. any other disease or disorder, injury, surgery, birth defect, or deformity?

h. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

2. **Within the past 5 years**, has any Proposed Insured:

a. been convicted of any misdemeanor or felony charge (including DUI or DWI), had a driver’s license suspended or revoked or is currently suspended or revoked, or any motor vehicle violations or is currently on probation or parole?

b. used illegal drugs, or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs?

c. participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving?

d. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft?

e. had application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed?

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

3. **Within the past 12 months**, has any Proposed Insured:

a. consulted a medical professional, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan?

b. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received?

☐ Yes ☐ No

☐ Yes ☐ No

SECTION B: Give details to all “Yes” answers in Section A and list current medications (use COMMENTS section on back for additional space).

Proposed Insured Name, Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		

UL201

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering IA American Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

IA American Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

COMMENTS: _____

AGREEMENT— I agree with IA American Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION — In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer’s business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) IA American Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize IA American Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB Pre-Notice. I acknowledge receiving the Accelerated Benefit Endorsement Disclosure Form.

Signed at (City) _____ (State) _____ Date of Application (MM/DD/YY) _____

_____ SIGNATURE OF PROPOSED INSURED	_____ SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)
_____ SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)	

AGENT ACKNOWLEDGEMENT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Benefit Endorsement Disclosure Form has been presented to the applicant.

Are you aware of any existing life insurance or annuity contract on the life of the Proposed Insured, except as noted in this application? ☐ Yes ☐ No
Are you aware of this policy replacing any existing life insurance policies or annuity contracts with this or any other company? ☐ Yes ☐ No

Agent Signature _____	Agent Printed Name _____	No: _____	% _____
Agent Signature _____	Agent Printed Name _____	No: _____	% _____

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured _____ Account Holder _____

Financial Institution (name/address) _____

Transit / ABA Number _____ Account Number _____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th) _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of IA American Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records) _____ DATE _____

UL201

IA AMERICAN LIFE INSURANCE COMPANY
P.O. BOX 2549, WACO, TX 76702-2549

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from _____ the sum of \$ _____ as first payment on this application for Proposed Insured _____ Date _____ Agent _____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization, a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company’s rules, are completed, and (4) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company’s rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, the liability of the Company shall be limited to the return of any amount paid.

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Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item:	Flesch Certification	
Comments:		
Attachment:		
ReadCert.pdf		

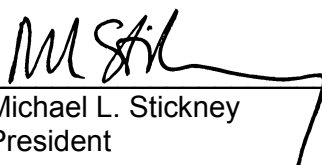


IA American Life Insurance Company
[17550 N. Perimeter Drive, Suite 210
P.O. Box 27650, Scottsdale, AZ 85255-0131]
888-473-5540 Toll Free
480-502-5088 Fax

CERTIFICATION OF READABILITY

IA American Life Insurance Company hereby certifies that the following form complies with state requirements for readability as follows:

UL201	SecureLife Plus Life Insurance Application	45.3
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Michael L. Stickney
President

October 15, 2010